

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

03-024653

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 149

Primary Registration District No. 1002 Registrar's No.

3102

STATE FILE NUMBER

63-024653

FILED JUN 17 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 65 Yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION King's Nursing Home		d. STREET ADDRESS (If outside, give location) 2737 Park Ave.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First GERTRUDE Middle CLARK Last UNTHANK			4. DATE OF DEATH Month May Day 30 Year 1963		
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/28/81	9. AGE (last birthday) 81 Yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY U. S. A.					

13a. FATHER'S NAME John Clark		13b. MOTHER'S MAIDEN NAME Maria Cornell		14. NAME OF HUSBAND OR WIFE Thomas C. Unthank	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Louise Montgomery K. C. Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arterio Sclerosis		DUE TO (b) Senility		DUE TO (c) -----	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arterio Sclerosis		DUE TO (b) Senility		DUE TO (c) -----	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY. Hour a.m. p.m. Month, Day, Year					

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION 5-30-63	COUNTY 5-30-63	STATE 5-30-63
21. I attended the deceased from 2-2-62 to 5-30-63 and last saw her alive on 5-30-63 Death occurred at 9.03 A m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE C. Turner	(Degree or title)	22b. ADDRESS 1433 E. 19th St.	22c. DATE SIGNED 5-31-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/1/63	23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri

24. FUNERAL DIRECTOR Mrs. Meek's Mortuary	ADDRESS K. C. Mo.	25. DATE RECD. BY LOCAL REG. 5-31-63	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

C. Turner

DATE AMENDED

VS 300
Rev. 4/59

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23408

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94500

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1286-0

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Millard B. Paskeins

Licensed Embalmer No.

5013

P. O. Address

N. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.